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UNITED STATES CIVIL SERVICE COMMISSION
Bureau of Retirement and Insurance
Washington 25, D. C.

March 4, 1960

Erratum Sheet For

REPORT OF PROGRESS ON THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM, MARCH 3, 1960.

In the recently issued Report of Progress on The Federal Employees Health Benefits Program, March 3, 1960, the Northern California Region of Kaiser Foundation Health Plan, Inc., Oakland, California, was inadvertently omitted from the list of group-practice prepayment associations which have been found eligible to submit health benefit plans for Commission consideration.

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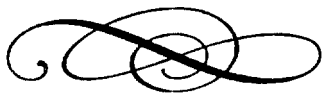
REPORT OF PROGRESS ON THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

March 3, 1960



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UNITED STATES CIVIL SERVICE COMMISSION
BUREAU OF RETIREMENT AND INSURANCE

REPORT OF PROGRESS ON THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM
March 3, 1960

This is the second report (the first was issued December 3, 1959) on the progress made by the Commission in implementing the Federal Employees Health Benefits Act of 1959. During the last three months considerable progress has been made in three main areas: information and training; approval of carriers proposing to offer health benefit plans, and drafting regulations. Activities in these three areas are discussed in detail below.

INFORMATION AND TRAINING

Regional Health Benefits Representatives

The Commission has designated an employee in each of its 11 Regional Offices as Health Benefits Representative. These representatives will assist the Regional Directors in carrying out the Commission's responsibilities under the Health Benefits program. One major duty of a Health Benefits Representative is to set up and operate a program of information and education aimed at Federal employees in his region. To assist in this activity the Commission has prepared a filmstrip explaining the Health Benefits program and giving the basic differences among the types of plans. The filmstrip will be shown to as wide an audience of Federal employees as possible.

Each representative has completed an intensive eight-day indoctrination in a variety of matters relating to the Health Benefits program. Immediately following completion of this training, the representatives conducted two one-day sessions on the Health Benefits program for approximately 500 representatives of agencies in the Washington, D. C. area who will have responsibility for health benefits activities within their respective agencies. The Regional Health Benefits Representatives have returned to their regions and are conducting similar programs for representatives of agency field establishments. These representatives will, in turn, explain the program to officials and employees in their own agencies.

Overseas Representatives

The Commission's Central Office has also trained selected agency personnel from overseas who will assume agency health benefits responsibilities upon return to their duty stations and will set up information and education programs for the 50,000 eligible employees overseas.

Additional Training

Two other indoctrination courses will be conducted in April. These include a follow-up four-day indoctrination (April 4 through 7) for the 11 Regional Health Benefits Representatives and a one-day (April 8) session for the 500 agency representatives from the Washington, D. C. area. The Regional Representatives will be provided with the latest details of the Health Benefits program, including information on the benefit structures and costs of the plans available to employees in their respective regions. They will also be brought up to date on enrollment and other procedures governing the operation of the program. The 500 Washington area representatives will be given this information as it pertains to employees in Washington.

Communications With Agencies

Departmental Circular No. 1024 and supplements to it are being used by the Commission to give official information and instructions to agencies as quickly as possible. The basic Departmental Circular was issued on October 6, 1959 and covered the Health Benefits program in a brief and general way. Since that date, five supplements have been issued on training, distribution of promotional literature, and accounting and reporting principles basic to the program.

HEALTH BENEFITS PLANS

Employee Organization and Comprehensive Plans

The Commission has considered applications and supporting evidence from a total of 113 employee organizations and group- or individual-practice prepayment associations which have applied for participation in the Health Benefits program. Of the 113, 42 have thus far been found qualified to offer a plan in which employees may enroll; 60 have been found not qualified because they do not meet all the requirements of the Health Benefits Act. Of the remaining 11, ten have withdrawn their applications and one is still under consideration. A listing of the qualified organizations and associations appears at the end of this report.

Each of the 42 eligible employee organizations and group- or individual-practice prepayment associations has been asked to submit its respective plan for approval. Many plans are already in; the remainder must be received in the Commission not later than March 7. This deadline has been extended from March 1 at the request of the carriers. The Commission is examining each of these plans for compliance with the minimum standards established for health benefits plans in the law and regulations, and will approve or, if necessary, request modification of a plan by early March.

Government-wide Plans

The Commission has selected the Aetna Life Insurance Company of Hartford, Connecticut, as the carrier of the government-wide indemnity benefit plan. The selection was made after evaluation of the experience and scope of operation of the 13 insurance companies in the United States which were found eligible - and well-qualified - to serve as the carrier under the criteria laid down by the Congress and the Commission. The Aetna was selected because it is the largest company in the group health and accident field which operates on a decentralized basis--a method of operation which should assure prompt service in handling employee claims.

Although the Aetna will be the carrier, it must cede reinsurance to all of an estimated 700 eligible insurance companies which apply to participate in the reinsurance.

To assure that the government-wide indemnity benefit plan will be the best that the health insurance industry as a whole can offer for the money available, the Commission has designated five men who are outstanding in the industry as an Insurance Committee to work with the Aetna and the Commission. This Committee will, among other things, assist in developing for Commission approval a formula for ceding reinsurance.

In the December 3, 1959 Report of Progress, the Commission noted that the Blue Cross-Blue Shield national organizations would write the government-wide service benefits plan. These organizations have contracts with thousands of doctors and hundreds of hospitals throughout the United States under which persons enrolled in their plans will be provided health services.

Development of Benefits and Costs

Frequent meetings have been held with the representatives of the Blue Cross-Blue Shield organizations, with the Insurance Committee and with representatives of Aetna. Out of these meetings have come the general pattern and many details of the benefits to be offered under the high and low level options of each of the Government-wide plans. A summary description of each carrier's tentative plan has been furnished the other and descriptions of both have been given to each of the approved employee organizations and group- or individual-practice prepayment associations for their information and guidance in formulating the plans which they will submit for approval. The Commission believes this exchange will assist carriers in devising the best plans possible.

The Commission appreciates that there is considerable public interest in what the specific benefits and costs of the various plans will be. However, since all of the plans are still subject to changes which could be substantial, the Commission believes that public release of information on benefits and costs which are now only tentative would result in confusion between the benefits and costs being considered and those finally agreed upon. After all plans which will participate in the program have been approved and contracts signed, the Commission expects to announce the specific benefits and cost of each.

REGULATIONS

The draft regulations, which were published in the Federal Register of February 2, 1960 as proposed rule-making, were extremely difficult to formulate. Comments on an initial draft were solicited and received from more than 50 sources and were carefully considered. These sources included the prospective carriers, employee organizations, the Health Benefits Advisory Committee, a special committee of the Interagency Advisory Group, selected to advise the Commission on procedural and other matters affecting agencies, and other interested parties. Comments on the February 2 draft regulations are still being received and will also be given full consideration prior to the promulgation of the regulations scheduled for the middle of March.

There was no unanimity on any single major provision of the draft regulations. In some instances, opinion on a particular point was--and still is--so diametrically conflicting as to make impossible completely satisfactory reconciliation of divergent views. Examples of these instances, together with the rationale of the draft regulations issued as proposed rule-making follow:

Practitioners of The Healing Arts

In response to many requests from individuals and from associations representing such groups as dentists, optometrists, podiatrists, chiropractors, osteopaths, and Christian Science practitioners, the Commission's initial draft of regulations contained a "non-discrimination" provision which would have required carriers to pay for covered services rendered by a licensed practitioner of any class.

This provision has been dropped from the current draft of regulations: The Commission will be contracting with the Blue Cross and Blue Shield, the Aetna Life Insurance Company, employee organizations and group- or individual-practice prepayment plans. The last named, as well as Blue Cross and Blue Shield, use their own practitioners. The Commission felt it could not require by regulation that these carriers contract with practitioners other than those they customarily and traditionally use. Since the Commission could not insist that these organizations use all practitioners of the healing arts, it could not fairly impose this requirement on carriers of indemnity plans.

As they now stand, the regulations do not bar payment to any class of practitioner. A carrier that chooses to do so can provide benefits to cover services of any class of practitioner.

Open Periods

In its Progress Report of December 3, 1959, the Commission stated an intention to have an annual two-week open period during which employees who had not enrolled could do so. During this period enrolled employees would also have been permitted to transfer freely from one plan to another. Desirable as such an arrangement would be from the employee's point of view, comment on a regulatory provision which would have permitted it made it clear that an annual open period would lead to "adverse selection"; e.g., employees could defer enrolling in a plan until they anticipated an illness; enrolled employees who had used up all benefits of the plan they were in (or could anticipate using them up) would simply transfer to another plan and thus, in effect, have unlimited benefits.

The Commission is of the opinion that the Health Benefits Act was not intended to allow an employee to obtain indirectly, through transfer from one plan to another, the unlimited benefits which he could not obtain directly if he stayed with one plan. Various solutions to the problem of open periods have been suggested. The one adopted by the Commission and included in the proposed regulations is that employees are guaranteed one open period; i. e., one opportunity to belatedly enroll in a plan or to transfer enrollment from one plan or option within a plan to another. This does not prevent the Commission from declaring additional open periods as and when a need for them arises. The draft regulations will permit belated enrollment or transfer outside the open period when a reason therefor arises (e. g., change in marital status).

Initial and Terminal Liability

Another extremely difficult problem has been that of determining where the dollars available should be spent in providing health benefits. Benefits provided an employee while enrolled in the plan need to be as generous as possible yet at the same time suitable coverage must be provided for an individual hospitalized at the time of initial enrollment or at the time enrollment terminates.

Traditionally, service benefit plans assume initial liability, while indemnity benefit plans assume terminal liability. Comprehensive medical plans, traditionally, provide benefits only during periods of enrollment, assuming neither initial nor terminal liability. None of these practices could be accepted by the Commission as suitable for plans to be included under the Health Benefits program.

Although they require all carriers to modify their customary practices, the proposed regulations provide that, with respect to initial liability, a plan may limit benefits to an individual who on the effective date of enrollment is confined in a hospital or other institution. This limitation can continue only until the individual is discharged from the hospital or institution.

Terminal liability was resolved as follows: A temporary extension of coverage of 31 days is provided for an individual whose enrollment terminates (other than by voluntary cancellation). If the individual is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension of coverage, benefits of his plan will be continued while he is so confined for up to an additional 60 days.

This arrangement will adequately cover most illnesses in progress at the time of enrollment or termination without seriously diminishing the benefits available during the period of enrollment. It is believed to be in the best interest of the greatest number of employees.

Employees in Non-Pay Status

Under the proposed regulations, employees--except those furloughed by reason of reduction-in-force--are given coverage up to 365 days while they are in a non-pay status. During this period, neither the Government nor the employee contributes to the cost of the coverage.

Carriers, generally, have objected to this provision primarily because they were uncertain as to what the cost of this "free" coverage might be and felt that it would require undue weighting of the subscription charge of a plan. The Commission, however, believes that the incidence and duration of leave without pay is overestimated by the carriers and that the weighting required is nominal---.35 of one percent of the subscription charges. As an example, the cost of a family enrollment in the least expensive option of either of the Government-wide plans should be weighted approximately five cents a month, of which the Government would pay half.

The Commission concluded it was only equitable to continue the coverage of employees in non-pay status because the great majority of them are either ill or are in a non-pay status for reasons which are to the Government's advantage (e. g. outside training).

Employees who are furloughed by reason of reduction-in-force are not given this 365-day "free" coverage for two reasons. First, if this coverage were allowed, they would be receiving preferential treatment over employees who were separated (without being furloughed) by reduction-in-force.

The second, and perhaps more compelling reason for exclusion, is the bankrupting impact possible mass furloughs could have on comprehensive medical plans which operate in limited geographic areas and derive most of their Federal employee enrollments from one or a few Federal installations.

Experience Rating

Except where it gives approval for a different rating system, the Commission is requiring that all approved plans be experience rated. This requirement has been objected to by a number of carriers. However, the Commission has held to its decision for the following reasons:

To permit the alternative urged by some carriers - community rating of a plan—would mean that its subscription charge would be based on the morbidity experience of the total community in which it operates, not solely on the basis of experience with the plan's Federal employee membership. Such a rating could result in the Federal employees (and the Government) being subsidized by or subsidizing other people in the community. The Commission believes that subsidies in either of these directions is undesirable, preferring that the Federal Employees Health Benefits program stand on its own feet. In the case of plans which clearly demonstrate that, from the nature of their operations experience rating is not practicable, substitute techniques will be worked out.

THE JOB TO BE DONE

In the relatively short time remaining before July 1, 1960, the following large segments of the implementation job must be completed:

- The health benefits plans of the various organizations eligible to submit them must be reviewed, modified if necessary, and approved.
- A contract for each approved plan must be drawn up and entered into by the carrier concerned and the Commission.
- Explanation of the basic differences among the types of plans must be given employees by their employing offices, primarily through use of the filmstrip prepared by the Commission.
- Literature describing each of the plans and options must be prepared, printed, and distributed to all eligible employees in every Federal installation throughout the world.
- Standard Forms, and procedures, including accounting procedures, which will govern the operation of the program have to be formulated.
- An estimated 1,800,000 employees must be formally enrolled in the program.

This task can be accomplished, but only with the continued co-operation of all Federal agencies, carriers, and the Federal employees themselves.

QUALIFIED ORGANIZATIONS AND ASSOCIATIONS

Employee organizations which have been found eligible to submit health benefit plans for Commission consideration are:

American Federation of Government Employees
Washington, D. C.

American Foreign Service Protective Assn.
Washington, D. C.

Federal Postal Hospital Assn.
Kansas City, Missouri

Government Employees Benefit Assn.
Ft. Meade, Maryland

Government Employees Health Assn.
Washington, D. C.

Group Health Insurance Board,
Panama Canal Company - Canal Zone Government Employees,
Balboa Heights, Canal Zone

National Assn. of Letter Carriers
Washington, D. C.

National Association of Post Office and General Services Maintenance Employees
Washington, D. C.

National Federation of Post Office Clerks
Washington, D. C.

National Federation of Post Office Motor Vehicle Employees
Washington, D. C.

National League of Postmasters of the United States
Washington, D. C.

National Postal Clerks Union
Washington, D. C.

National Rural Letter Carriers Assn.
Washington, D. C.

Special Agents Mutual Benefit Assn.
Washington, D. C.

United National Association of Post Office Craftsmen
Washington, D. C.

Group-practice prepayment associations which have been found eligible to submit health benefit plans for Commission consideration are:

AF of L Medical Service Plan
Philadelphia, Pennsylvania

Kaiser Foundation Health Plan of Oregon
Portland, Oregon

The Bridge Clinic
Seattle, Washington

Farms Union Hospital Assn.
Elk City, Oklahoma

Group Health
St. Paul, Minnesota

Group Health Association, Inc.
Washington, D. C.

Group Health Cooperative of Puget Sound
Seattle, Washington

Group Health Services Assn.
Detroit, Michigan

Hawaii Region of the Kaiser Foundation Health Plan
Honolulu, Hawaii

Health Insurance Plan of Greater New York
New York, New York

National Health Plan
Los Angeles, California

Pacific Health Plan Medical Group
Los Angeles, California

Physicians & Surgeons Assn.
San Francisco, California

Ross-Loos Medical Group
Los Angeles, California

Southern California Region of Kaiser Foundation Health Plan
Los Angeles 4, California

St. Louis Labor Health Institute
St. Louis, Missouri

Union Health Service, Inc.
Chicago, Illinois

Western Clinic
Tocoma, Washington

Individual-practice prepayment associations which have been found eligible to submit health benefit plans for Commission consideration are:

Group Health Insurance Incorporated
New York, New York

Hawaii Medical Service Assn.
Honolulu, Hawaii

Hospital Service, Inc.
Fort Collins, Colorado

National Hospital Assn.
Portland, Oregon

North Idaho District Medical Service Bureau
Lewiston, Idaho

San Joaquin Foundation for Medical Care
Stockton, California

Seattle Letter Carriers Medical Service, Inc.
Seattle, Washington

Washington Physicians Service
Seattle, Washington

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